



'Hearing Voices': Punishing Women's Mental Ill Health in Northern Ireland's Jails

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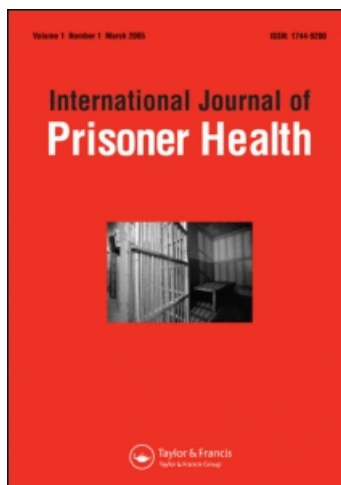
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ORIGINAL ARTICLE

‘Hearing Voices’: Punishing women’s mental ill-health in Northern Ireland’s jails

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Abstract

Informed by primary interviews and observational research conducted by the authors with women prisoners in Northern Ireland, this article focuses on prison as an institutional manifestation of women’s powerlessness and vulnerability, particularly those enduring mental ill-health. It contextualises their experiences within continua of violence and ‘unsafety’. It also considers official responses to critical inspection reports and those of the Northern Ireland Human Rights Commission based on the authors’ research findings. Finally, the primary research demonstrates that three decades on from publication the first critical analyses of women’s imprisonment, the conditions of gendered marginalisation, medicalisation and punishment remain. This is brought into stark relief in the punitive regimes imposed on those most vulnerable through mental ill-health.

Keywords: *Mental health, Northern Ireland, prisons, punishment, self-harm, strip search, women prisoners*

Introduction

Between 2004 and 2007, the authors conducted primary research with women in prison on behalf of the Northern Ireland Human Rights Commission (NIHRC). The research was commissioned following the death in a punishment block strip cell of 19-year-old Annie Kelly in September 2002 and the publication, in 2003, of a highly critical Prisons Inspectorate report. At the time, all women prisoners in Northern Ireland were held in the Mourne House unit of Maghaberry prison, a category ‘A’, high-security male prison. Although the women’s prison population was relatively small, it was a complex mix including lifers, remands, committals, detainees, politically affiliated prisoners and ‘young offenders’. Evaluating compliance with international human rights law and standards, in particular with Articles 2 and 3 of the European Convention on Human Rights (the right to life and the right to be free from torture, inhuman and degrading treatment), was central to the research.

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In-depth research interviews and focus groups were held with: women prisoners; prison officers and their representatives; professionals working in the prison including education; probation; health care staff and clergy; and the Board of Visitors. Semi-structured interviews focused on reception and induction; prison routine; education; activities and programmes; physical and mental health care; discipline; contact with families; relationships between prisoners and prison officers; and preparation for release. Eighteen women and girls were interviewed in-depth from a population of 23, several more than once. All but two women participated in group discussions.¹ Granted unprecedented access to the prison, the authors also observed the prison regime and routines, including observation in the health care centre and punishment/isolation cells. During the research another young woman, Roseanne Irvine, took her own life in controversial circumstances. Highly disturbed, she had just been moved from strip conditions in the punishment block (see Scraton, 2007). The published research received considerable media coverage (Scraton & Moore, 2005).

In June 2004, Mourne House closed and women prisoners were transferred to Ash House, a unit in the male Hydebank Wood Young Offenders Centre, near Belfast. Ash House had a certified capacity of 56 women in single-cell occupancy. Following initial refusal by the Prison Service, permission to conduct fieldwork was eventually granted and conducted between December 2005 and March 2006. Thirty-four women prisoners were interviewed and the researchers spent considerable time observing the regime.² Although representatives of all professions working in the prison and all senior prison managers and officials were interviewed, few prison officers openly participated. Following publication of the research (Scraton & Moore, 2007), the NIHRRC lobbied for: provision of a discrete women's custodial facility with an international human rights standards compliant regime; removal from the prison system of women suffering mental ill-health; an independent public inquiry into the circumstances surrounding the deaths of Annie Kelly and Roseanne Irvine and the deterioration in the Mourne House regime.

Given their personal histories and the vulnerability associated with deprivation of liberty, research with prisoners raises challenging ethical issues. These include the principle of informed consent while ensuring no harm – physical, psychological or emotional – is caused to prisoners. At the outset, written information was provided for prison staff and for prisoners and informed consent was gained for each interview. Interviews were voluntary and women had the right to withdraw their interview at any point. They were interviewed privately and not in the presence or hearing of staff although on occasion they chose to engage the authors in the presence of prison officers. Throughout the observational fieldwork, including case conferences, all parties were aware of the role of the researchers. Interviews were confidential and anonymity guaranteed. Senior managers and officials, however, were referred to by job titles in the reports.³

Women's 'pains of imprisonment': academic accounts

Pat Carlen's definitive 1983 study of women in prison, concluded that while most women were imprisoned for 'purely punitive purposes' (Carlen, 1983, p. 23), a 'high proportion ... have been diagnosed as having either 'personality disorders' and/or alcohol and/or other drug-related problems' (Carlen, 1983, p. 22). Many described physical abuse at the hands of husbands, cohabitees, male relatives or police officers. They were judged, assessed and classified on their capacity for social interaction, on their femininity in terms of

appearance, tidiness, motherhood and on their maturity by prison officers, governors and medical staff.

There was 'little sympathy regarding pre-menstrual tension and even less recognition of their need for increased access to washing facilities during menstruation' (Carlen, 1983, p. 104). Twenty years on, Carlen and Worrall (2004, p. 61) noted greater acceptance 'that women's health care needs in prison – both physical and mental – are more various and complex than men's ... but the overwhelming experience of women in prison is that their health needs are not consistently dealt with in a respectful and appropriate way'. These included: 'pregnancy, cervical cytology, and breast cancer screening, and miscellaneous hormonally-triggered "women's ailments" ... chronic mundane conditions'.

Joe Sim's comprehensive analysis of the history of prison medical intervention acknowledged 'the continuing entrapment of women within catch-all psychiatric categories such as behavioural and personality disorder' (Sim, 1990, p. 176). Carlen (1983, p. 194) showed how the 'temporary classification 'disorderly', gradually ossifies into the more permanent 'disordered' ... untreatable ... beyond the remit of the treatment agencies, without hope and beyond recognition'. The majority of women prisoners had histories of mental illness yet were 'clothed' with the disciplinary needs of the 'disordered' (Carlen, 1983, p. 196).

Diagnoses centred on the disputed 'concepts of personality disorder and anti-social personality disorder'. Those classified 'mentally ill' were prescribed drugs, while the 'not mentally ill' were subjected to 'normal penal methods of deprivation of liberty and other forms of deprivations' (Carlen, 1983, p. 206). 'Personality disordered' prisoners were considered untreatable – 'bad' rather than 'mad'. Once the classification was attributed, the status ascribed, the woman prisoner had 'little chance of having the label removed' (Carlen, 1983, p. 209). Applied as a fixed, permanent category, it carried 'little hope of change'.

More recently, Carlen (1998, p. 10) notes that women's imprisonment continually 'incorporates and amplifies all the anti-social modes of control that oppress women outside the prison'. As Vetten and Bhana (2005, p. 265) state, 'similarities between imprisonment and abusive relationships [outside prison] are profound ... characterized by authoritarianism, a marked power imbalance, enforced restriction of movement and activities, lack of freedom of association, violence and enforcement of arbitrary and trivial demands' resulting in 'compliance with others' demands ... defensive violence, suppression of feelings'. The prevalence of punitive regulation establishes a persistent reluctance to reveal distress. Women prisoners 'must quickly learn to disengage from their emotions' in the knowledge that any sign of weakness, 'will be reported to corrections officers by psychologists' and 'lead to the isolation unit' (Walsh, 2004, pp. 22–23).

Further, prison regimes for women regularly fall below minimum standards of decency and humanity: 'so many women arrive in prison suffering from extreme health and social effects of poverty, addictions and physical and sexual abuse' yet no 'coherent or holistic policy is in place to manage their sentences' (Carlen, 2002, p. 15). As Lowthian (2002, p. 177) demonstrates, the institutional response typically dehumanises through inadequate health care, high security, bullying, self-harm and suicide, absence of constructive programmes and long periods of isolation.

Women 'are likely to suffer more pains of imprisonment than men, and to suffer in different ways' (Carlen, 1998, p. 10). They experience strip searches as assaults on bodily integrity, particularly damaging for those previously subjected to violence and abuse. Davis (2003, p. 81) considers sexual abuse 'is surreptitiously incorporated into one of the most habitual aspects of women's imprisonment, the strip search'. Carlen (1983, p. 80) also noted the inhibiting impact of strip searches on family visits, leaving mothers 'torn between'

the 'desire' to see their children and the 'desire to shield them from the pain of the experience'. At the moment of intense, emotional and public strain in meeting and leaving their children, mothers were forced to strip before returning to the isolation of their cells.

Imprisoned women in Northern Ireland: from conflict to controversy

Until 1986 women prisoners in Northern Ireland were held in Armagh Jail, built between 1780 and 1819. It was replaced by Mourne House. Constructed and staffed primarily to hold politically affiliated, high-security prisoners, it was a prison within a prison. Corcoran (2006, p. 22) notes, as at Armagh, the 'needs of male prisoners prevailed over those of the women in the allocation of resources and facilities'. They endured inadequate diet, poor medical provision, lack of trained medical orderlies and paternalistic education provision. Punitive, violent strip searches had a profound impact, 'designed to humiliate, to degrade', halting menstruation and inducing 'anxiety attacks' (Pickering, 2002, p. 179). Guards' use of physical force and verbal abuse was matched by institutionalised formal punishments. By 'taking control of women's nakedness' guards imposed authority while 'breaking' resistance – a process 'understood by women ... who had experienced strip searching as being particularly vicious' (Pickering, 2002, p. 181).

The 1998 Good Friday/Belfast Agreement initiated the early release of most political prisoners yet Mourne House continued as a high-security unit. In 2003, the Prisons Inspectorate recorded the 'potential dangers' inherent 'in situations where the needs of a small group of women ... become marginalised' (HMCIP, 2003, p. 1). The inspectors recognised that male violence and abuse in women's personal histories contributed to their vulnerability. Shared prison transport with male prisoners brought sexual taunts and verbal abuse. Staff failed to keep adequate records of self-harm or the 'excessive' use of strip searches. Self-harming and suicidal women, particularly girls and young women, were transferred either to the male prison hospital or the women's punishment block, where inspectors found a 15-year-old, self-harming child in strip clothing.

A Northern Ireland Prison Service (NIPS) review of generic prison health care noted health needs 'of a multiply deprived population with high levels of chronic disease, mental illness, addiction problems and self-neglect' (NIPS, 2002, p. i). There was no mention of women prisoners' specific needs, either reproductive or those resulting from women's histories of abuse. A year later NIPS (2003, p. 3) published a draft policy on self-harm and suicide prevention. It proposed 'maximum contact and support' to be provided by 'staff and persons outside the prison'. Guards would be made aware of their potential 'positive contribution' through 'improving the quality of life for prisoners in their care'. It affirmed that all staff had 'an equal and continuing responsibility for the management of prisoners considered to be at risk of committing suicide or other acts of self harm' (NIPS, 2003, p. 5).

When 19-year-old Annie Kelly, a young woman who had been in the adult jail 28 times since she was 15, took her own life in a punishment block strip cell serious questions were raised regarding the Prison Service's apparent failure to meet its duty of care.

'The Hurt Inside': findings from the Mourne House primary research

Having anticipated improvements in regime and programmes and evidence of strategy, policy and staffing reform as a consequence of the negative inspection and Annie Kelly's death, the research revealed further deterioration. Diminished programmes reflected an all-pervasive climate of indifference and complacency. No corporate strategy, no gender-specific

policies, no discrete management structure and no gender-oriented training had emerged. Workshops were permanently closed, women rarely escorted to education. They were locked alone in their cells for a minimum 17 hours a day, often 23 hours, unable to phone their children. There was minimal support on reception, no structured induction programme. Male guards comprised 80% of day staff, often rising to 100% at night. Recommended sentence management and resettlement programmes had not materialised (see, Scraton & Moore, 2005).

Self-harming young women were held in the punishment block. A child, flesh torn and cut from her ankles to her hips, hands to her shoulders, dressed in a canvas gown, no underwear even during menstruation, was locked 23 hours a day in the strip cell where Annie Kelly had died. She lay on a concrete plinth, without a blanket or pillow. A grandmother – epileptic, diabetic, colostomy bag and weeping varicose veins – was held in solitary for abusing officers. Another prisoner commented:

She ate with her fingers. They'd taunt and laugh at her by blowing smoke through the door. She tried to hang herself and three of us saw her getting out of the ambulance. They walked her across the tarmac in February with a suicide blanket on. They all had riot gear on. She was crying. They were bringing her back from hospital and she was put back in the punishment block. We just kept our heads down. Just did our time.

This was how self-harming and ill women were 'managed'. During the research Roseanne Irvine, took her own life having been held in the block, fearing loss of access to her child and tearing out her hair (see, Scraton, 2007). Ill, vulnerable women were accommodated in the male prison hospital where, in the immediate aftermath of Roseanne's death, her friend stated:

The staff don't care. They [male prisoners] talk filthy and dirt with the other prisoners. A man exposed himself. Said, 'I'll give her one'. He thought 'I'll pull it out 'cos there's a woman there'. We were all outside together. Told them [staff] about what the man did but they never did anything about it. I didn't feel safe around them. I've never been in prison before. I hate getting locked up it brings memories back to me. I'm lying trying to sleep, thinking about these things [previous sexual abuse].

Counselling and therapy was not available, the situation particularly bleak for those classified 'personality' or 'behaviour' disordered. Assumed untreatable, they were 'managed' by poorly trained guards. Inevitably this led to the punishment block.

Among extensive recommendations the research prioritised the need for a discrete women's custody unit, the establishment and resourcing of gender-specific regimes and programmes. It called for an end to holding children in prison custody, using punishment cells for self-harming women and mandatory strip-searching. Absolute separation from male prisoners was an imperative.

In April 2004, the Prison Service introduced the Prisoner at Risk (PAR1) procedure to manage prisoners whenever possible on normal residential landings. The PAR process would provide help 'during a difficult period when [the prisoner] may be at risk of self-harm or following self-harm'. Staff should 'record what the prisoner says about his/her situation' and suggest 'what you think should be done about it' (NIPS, undated a, p. 1). Another document, defined self-harm as 'any act where a prisoner deliberately harms themselves irrespective of method, intent or severity of any injury' (NIPS, undated b).

The transfer to Ash House, Hydebank Wood

Two months later, amid public controversy, women prisoners were transferred to Ash House, in Hydebank Wood male young offenders centre. Although technically 'low security', the women's unit was adjacent to the young men's accommodation – seriously inhibiting women prisoners' access to the site. Cells were small, lacked in-cell sanitation and women's escorted movements within the site or during transportation were met with constant verbal abuse from the young men. Five months after the move an inspection raised serious concerns about 'the extent to which Ash House can provide a suitable environment for women' (HMCIP/CJINI, 2005). The transfer had been 'poorly implemented', failing to provide 'specialist training, management or support to ensure that they could properly look after the women and girls in their care' (HMCIP/CJINI, 2005).

A 'documented health needs assessment had not been undertaken' to meet the 'specific healthcare needs of women' (HMCIP/CJINI, 2005, p. 35). While Ash House was responsible for 'some very difficult and damaged women and girls with high levels of mental health needs and traumatic histories', the Inspectorates found 'evidence of inappropriate care with little therapeutic focus' (HMCIP/CJINI, 2005, p. 24). They criticised the 'inappropriate treatment of young women at risk, some of whom were children ... held in unfurnished cells for long periods with few personal possessions'. One young woman had been clothed in an uncomfortable anti-suicide gown for over seven weeks (HMCIP/CJINI, 2005, p. 25). Women's 'problem behaviour' was managed exclusively by punishment and they were reluctant to disclose 'feelings of vulnerability' due to 'fears of how staff would respond' (HMCIP/CJINI, 2005, p. 26).

In a climate of 'victimisation', procedures 'for managing suicidal or self-harming women were inadequate' (HMCIP/CJINI, 2005, p. 10). They were 'disciplined for self-harming' and 'difficult behaviour of disturbed and distressed women was characterised as 'bad' behaviour to be punished'. A woman identified at risk, kept in an anti-suicide gown, was 'not allowed to use the toilet over lock up periods until further notice' (HMCIP/CJINI, 2005, p. 26). A PAR entry recorded a prisoner with a colostomy bag demanding to slop out yet told that she would not be unlocked. Hours earlier a guard had found her 'lying on her back, plastic bags tied tightly around her neck and her face was black. I cut the bags with the knife and her breathing and colour returned to normal'. She was transferred to a 'separation and support unit' in the male young offenders centre. There were 'no routine investigations into incidents of self-harm' and 'little counselling provision for victims of physical and sexual abuse' (HMCIP/CJINI, 2005, p. 26). Several months on from Mourne House, in a different location, the Inspectorates graphically reported minimal progress towards appropriate care for vulnerable women.

Alvaro Gil-Robles, Commissioner for Human Rights for the Council of Europe, considered there was 'no possibility for the women to receive appropriate treatment, indeed, the conditions could only be considered likely to aggravate their fragile condition still further'. He recorded the lack of appropriate psychological care and the precarious mental health condition of some women (Gil-Robles, 2005, para. 126). The Committee on the Prevention of Torture also described 'unacceptable conditions' for women including: 'a lack of gender-sensitive facilities, policies, guarding and medical aid'.

'The Prison Within': findings from the Ash House primary research

Drug- and alcohol-dependent women invariably entered the prison in poor physical health, highly disturbed and emotional. They required specialised and personalised medical care

sensitive to their social as well as psychological and physiological circumstances. While clinical assessment on arrival was policy, women's experiences reveal arbitrary, inadequate provision and withdrawn medication:

I was asked if anything had changed with my notes. Then it was off to the cell and nothing to help me sleep at night. Women coming in need something to calm them down and help them through the first night.

The psychiatrist hasn't seen me for 26 days. They go on about the teams they have. They make it sound like the Priory. But when you get here the harsh reality is you're left to do it [detox] on your own.

I had a really bad first night, it was a nightmare, I was hot and cold and started withdrawing.

Pressures of living in a volatile, uncaring atmosphere were immediately apparent:

One of the prisoners tried to hang herself. We knew something was wrong, she was making funny noises and I pressed the panic button. [Guards shouted] 'It's only Mad Mary'; 'She could have least set it up properly'. They C and R'd [Control and Restraint] her and put her down the Block. You're behind the door and don't know what to do. I wanted her to be treated with respect. She needed help. It only took a few seconds to treat her as a person, not a piece of scum. A week later she set herself on fire. She was on a PAR1 ... We had to live with the smell. I couldn't stop crying for days and I was moved. I have lost about five friends and it brought it all back. It was the feeling that they didn't want to help her. Even when I didn't want to cry the tears kept coming.

The committal landing, accommodating new arrivals, fine defaulters and others on short sentences failed to provide a settled and therapeutic regime for those entering prison distressed and vulnerable:

I had to strip and shower. I was embarrassed. I seen the nurse when I was down there. They said they'd put me on a PAR1. I was in on Friday and stayed 'til Tuesday until I'd seen the psychiatrist. I tried to strangle myself and they brought me to the 1s [A1: Special Supervision Unit/Punishment Block]. I still get days like that. My moods are all over the place. I felt the staff were against me. They put me into a camera cell and made me wear a canvas dress and took everything off me. The things don't fit you, they're not tight on you. I just felt embarrassed. You need staff who understand and they know what you are talking about.

During unlock on A1 a few women occupied a large, bare recreation room. Floors, walls, furniture and facilities were basic. They sat on hard chairs at canteen-style tables smoking roll-ups. Daily routine consisted of 'doing nothing' and a 'craft class' was held once a week. Guards sat at a desk in the access area between the recreation room and the cell corridor. The punishment block was located alongside the 'special supervision unit' clearly demonstrating the juxtaposition of 'treatment' and 'punishment' for those identified as 'management problems'. A young woman prisoner stated: 'People for punishment shouldn't be put in A1 with vulnerable people'. A professional worker confirmed A1 'as

punishment ... a punishment wing'. She believed, 'A1 should only be used if there's a serious risk of harming themselves'. Women prisoners commented:

They punished me for cutting myself. I'm still hearing the voices and I'm not on the right medication. When I'm unlocked I'm doing nothing at all, just sitting here smoking. The nurse comes and gives me tablets but I'm not getting the right medical help in here. The doctor says he can't help me.

I really need someone to talk to you. I get no counselling whatsoever. When I was on 23 hour lock up the staff didn't even bother to talk to me. I was just stuck in the cell with a camera. Being in the cell with a camera there's no privacy or nothing. Your dignity's taken away from you. They just said, 'It's your own fault you're behind the door'.

As a relatively small group of vulnerable women, they experienced significantly worse conditions than those on other landings. They were 'often locked' during evening association:

I asked if I could use the phone but there was other people using our phone and we were locked.

This is a vulnerables' landing and we should be out [of their cells] more. When you're in your cell things go through your head.

Because we've got problems if we're locked in our cell so long things get to us. You just dwell on stuff.

We get nothing just two hours when someone comes over to do stuff each week. We don't even have a radio in the [recreation] room.

And the only work we get is cleaning.

Isolation was difficult to handle: 'When you're in your cell with the door closed only if you're really, really ill does the door open. From quarter to four to eight the next morning—that's a bit of a lock-up'. A remand prisoner identified the consequences of isolation:

I get a lot of thoughts and visions. It makes me down. It [self harm] relieves the tension. [Outside] I used to go to a day centre which was helpful. You were among people. Sometimes in here I feel so isolated.

Lack of outside contact heightened isolation: 'My Mammy phoned in to say that my sister had had a wee girl but I didn't get the message. She leaves messages to be passed on but it doesn't happen'. Monitoring calls and letters created further anxiety: 'It freaks me out, it gets me going to think they've read my letters about my son and the letter's been sitting there in the office'.

A self-harming prisoner was informed by telephone that her bail application had stalled indefinitely. She returned to the table crying. Minutes later a prison officer walked to the door and shouted 'Lock up'. Clearly distressed, the woman apologised to the authors, rose from the table and shuffled, sobbing, to her cell. It proved to be the beginning of a

particularly difficult period during which she self-harmed and was transferred to a strip cell in the health care centre.

The contradictions and tensions between treatment and punishment, between care and coercion, are well illustrated in the following comments:

All of us women are vulnerable, we're all vulnerable. Three weeks I was on the 1s [A1] and it did my head in. I was there for punishment and it did my head in. Sometimes I go [for counselling] but how do we know if she's talking to staff?

Where's the care in healthcare? If I'm feeling down they say there's always someone available and there isn't. If you start questioning anything or you say you have a problem they up the medication. They've made me dependant on anti-depressants.

Women with mental health problems regularly expressed fear of isolation both on A1 and in the health care centre:

They put me in the observation cell from Friday to the Monday. I'd gone through a great loss. I was just out [of her cell] for the shower, no interaction, nobody asking to speak with me. I'm shit scared of going back to the hospital. There's nothing. So I say I'm fine. There's no therapeutic help, nothing.

A young woman, admitted several times to the health care centre strip cell, stated:

You didn't get out at all but to get a shower. You were on your own. They only came to give you dinner and medication. That was it. It made you worse than you were.

A woman held in the health care centre had been admitted to prison following a period in hospital recovering from serious injuries. Her persistent pain and debilitation were apparent. Coming to terms with the recent death of her partner, the sudden transition from hospital to the prison health care centre had been emotionally shattering.

It depends who's on as to how much time you have out of your cell. It's terrible how long you're locked up in your cell. You get 10 or 15 minutes association if you're lucky. It's up to them when you have a bath. They say, 'Maybe we'll go out this afternoon' [for recreation] but it never happens. They never tell you enough. I don't know what's happening and it's just taking one day at a time.

Women most in need of personal support, therapeutic interaction and constructive activity were fearful of A1 and the health care centre, the two places in the prison designated to respond to mental health needs. As a psychologist commented:

Reduced lock up would ease tensions. It's often the quiet of night when there's less activity. People are more reflective and introspective and vulnerability becomes magnified. Yet there's limited access to support. Within the constraints of the prison therapeutic work is limited.

A1 was a soulless environment in which women on punishment were unlocked one hour each day while those considered 'vulnerable' had minimal opportunity for social interaction or association. It was characterised by an absence of meaningful or constructive activity.

The regime was debilitating and demoralising. As the prisoners' accounts demonstrate, such conditions were not conducive to heightening self-esteem or building confidence. Quite the opposite, it was a regime of mind-numbing boredom and personal self-loathing, exacerbating the very risk it sought to manage and eliminate. Ill-fitting, cumbersome and ugly anti-suicide gowns were the public manifestation of the perceived dysfunction within. These were processes of individual pathologisation in which security was prioritised above care. While kept physically alive, women were regularly emotionally and socially broken.

The health care centre was staffed by poorly trained and under-qualified prison nurses who failed to identify and meet the complex demands of women with histories of abuse, self-harm, parasuicide and mental ill-health. Locked for long periods in barren strip cells, there was nothing to engage or occupy those already in the depths of despair. That this had become acceptable to care providers, to staff, to management, to headquarters and to the independent monitoring board was an indictment of their institutionalised acceptance of the unacceptable. Whatever the reasons given – shared facility with young male prisoners; poor female to male staff ratio; too few registered mental health nurses – there could be no justification for the operational regime within the health care centre. It bore no comparison to equivalent provision in the community.

'Everything revealed'?

Both authors provided written and oral evidence at the inquests into the deaths of Annie Kelly and Roseanne Irvine. They also had access to the internal reports and medical histories of the women. While the cases are written up extensively elsewhere (Moore & Scraton, 2008; Scraton & Moore, 2005, 2007; Scraton, 2007), it is instructive to consider the narrative verdicts delivered by the inquest juries. Both women, with histories of severe self-harm, self-evidently had taken their own lives. Yet the Annie Kelly inquest jury stated that she did not die 'by her own hand'. Her death was a consequence of 'lack of communication and training at all levels' – prison managers, governors, guards and health care professionals. There had been 'no understanding or clear view' of organisational roles in the 'management and understanding of Annie' and a 'major deficiency in communication between Managers, Doctors and the dedicated team' responsible for her health, welfare and safe custody. Appropriate policies, management and staff training did not exist and there was 'no consistency in her treatment and regime from one Governor to the next'.

The Roseanne Irvine inquest jury concluded: 'The prison system failed Roseanne'. She had acted while the 'balance of her mind was disturbed'. Reflecting on extensive and contradictory prison officers' and managers' evidence, that revealed a fatal mix of complacency, incompetence and negligence, the jury noted the significance of self-harm and punishment 'leading up to her death', her mental ill-health and her treatment immediately prior to her death. 'Defects' in the system were: 'Severe lack of communication and inadequate recording'; 'Lack of healthcare and resources for women prisoners'. They considered the prison hospital 'inadequate for female prisoners'.

Shaylor (1998, p. 386) considers 'control units' to be the 'ultimate regulation of the female body'. In name, control units did not exist in Mourne House but the tragic cases of Annie Kelly and Roseanne Irvine show how punitive isolation in strip conditions is used to 'manage' self-harming and parasuicidal behaviours. The Block was a control unit in all but title. Shaylor (1998) proposes that solitary confinement is indicative of 'increasing brutality in women's prisons', including the persistent and often gratuitous use of strip searches.

In her final letter home Annie Kelly recalls a particularly violent strip search that preceded her death:

Then they all held me out in the corridor. I only had the suicide dress on and I was told I could keep my pants cause I'd a s.t. on. But when the men were holding me they got a woman screw to pull my pants off. That shouldn't have happened. Then they covered me in celatape to keep the dress closed and handcuffed me and dragged me off to the male hospital. I've hung myself a pile of times. I just rip the dress and make a noose. But I am only doing that cause of the way their treating me. The cell floor is covered in phiss cause they took the phiss pot out the other night. Their flies in the cell. They won't let me clean it. I haven't had a shower now in 4 days. I've had no mattress or blanket either the past few nights.

She concluded:

At the end of the day I know that if any thing happens to me there'll be an investigation. So if I take phenumia it'll all come out. I know they'd all love me dead but I'd make sure everything is revealed first.

Both women died in the final throes of the Mourne House regime. Following its closure managers and guards constantly referenced the distinctive needs of women prisoners. Yet the research demonstrated: institutional failure to address health care provision along 'well-woman' principles; the severe impact on women of intimate bereavement; the failure to address needs of those with histories of physical and/or sexual abuse; and the daily pain of separation from children. It was also apparent that the inter-relationships of gender, sexuality, ethnicity, age and disability were not on the policy agenda.

While regimes and programmes were not gender specific in design or delivery, regulation, control and punishments were consistently gender specific. Fear, degradation and dehumanisation endured by women prisoners were institutionally genderised; most appropriately represented and analysed through their location on continua of violence and unsafety. This ranged from lack of access to telephones or baths, through lock-ups, to strip-searches, personal abuse and punishment. Regarding violence, the sharp end of the continuum, where the woman's body is the site of self-harm and of strip searches, was related directly to the sexual comments, innuendo and insults embedded in the prison's daily routine.

Reflecting on the recent history of women's imprisonment it is self-evident that medicalisation plays a significant part in setting agendas for institutional responses, both collectively and individually. Those classified as behaviour or personality disordered are represented as 'not genuinely' mentally ill, condemned for punishment. While prison managers predicate discussion of the 'mentally ill' by arguing they 'should not be in a prison' the bottom-line is that they are – and in increasing numbers. There they experience places of extra confinement and isolation, increased deprivation and asocial existence. A quarter of a century on from Pat Carlen's study it remains a major issue that the most depressed and vulnerable women, at the optimum moment of personal risk, are placed in the most punitive conditions bereft of appropriate, responsive support.

The research identified the unmet needs of women prisoners against a backdrop of violence and restraint, strip searching and the systemic denial of bodily integrity, self-harm, segregation, appalling physical and mental health care in the contexts of facilities shared with men, punitive detox programmes, minimal contact with families and children,

bereavement, inadequate preparation for release and authoritarian, poorly trained guards. Discrete accommodation, gender-specific policies, regimes and programmes are the necessary objectives for short-term reform but the long-term objective should be abolition of women's imprisonment replaced by a range of fully resourced, community-based and residential alternatives.

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Notes

- 1 The population of the six counties of Northern Ireland is approximately 1.75 million. At the time of the research, women constituted 3% of the average prison population. The average weekly women prisoner population rose steadily from 22 at the outset of the research to 44 on completion in 2007.
- 2 While this number was slightly higher than the average weekly population, it is explained by new arrivals during the four months of fieldwork.
- 3 The Northern Ireland Prison Service was given access to the reports for comment on accuracy prior to publication.

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